TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GRAPEVINE SURGICARE

Respondent Name
TEXAS ASSOCIATION OF COUNTIES RMP FOR WICHITA COUNTY, SELF-INSURED

MFDR Tracking Number
M4-16-3524-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are allowed an additional payment of $1670.13."

Amount in Dispute: $1,670.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has properly audited and paid the bill in question."

Response Submitted by: Parker & Associates, L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 28, 2016	Ambulatory Surgery, procedure code 63650	$1,670.13	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the medical fee guideline for ambulatory surgery centers.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. What is the recommended reimbursement for the disputed ambulatory surgeries?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards reimbursement for ambulatory surgery services subject to 28 Texas Administrative Code §134.402(f), which requires that the calculation used to establish the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 Federal Register, or its successor, with minimal modifications as further specified in the rule.

   Review of the submitted information finds that the disputed services are device-intensive procedures. Separate reimbursement of implantables was not requested.

   The following minimal modifications shall therefore apply per Rule §134.402(f)(2):

   > Reimbursement for device intensive procedures shall be:
   > (A) the sum of:
   > (i) the ASC device portion; and
   > (ii) the ASC service portion multiplied by 235 percent;

   Reimbursement is calculated as follows:

   - Procedure code 63650, service date March 28, 2016, has status indicator J8, denoting a device-intensive procedure reimbursed in accordance with Rule §134.402(f)(2). Per Medicare Addendum AA, this code is not subject to multiple procedure discounting; the payment rate is $3,993.90. This amount is divided in two halves, representing the labor-related and non-labor-related portions of $1,996.95 each. The labor-related half is geographically adjusted by multiplying it by the annual wage index for this facility's location of 0.9526. The adjusted labor portion is $1,902.29. This amount is added back to the non-labor half. The sum is the Medicare ASC facility rate of $3,899.24.

     The device-offset percentage of 0.5619, from Medicare's *Table of ASC Designated Device-Intensive Procedures*, is multiplied by the OPPS rate for this procedure code (as listed in Medicare Addendum B) of $5,244.37, which yields an ASC device portion of $2,946.81. This amount is subtracted from the facility rate, leaving a service portion of $952.43. This amount multiplied by the Division conversion factor of 235% is $2,238.21. The device portion is added back to the adjusted service portion for a MAR of $5,185.02.

     The surgeon performed two units of this procedure. Multiple procedure payment reduction is not applicable.

     The total MAR for both units is $10,370.04.

2. In reviewing the payment calculation information submitted by the requestor, the division notes that the requestor did not take into account the ASC device portion calculation required by Rule §134.402(f)(2)(A)(i), and therefore the amount sought by the requestor did not match the correct payment amount calculated under the fee guideline. The total allowable reimbursement for the services in dispute is $10,370.04. The insurance carrier has paid $10,933.88; consequently, no additional payment is due to the requestor.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the information submitted by the parties, in accordance with the provisions of Texas Labor Code §413.031, the division determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	February 10, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.